

VIRGINIA MEDICAID REQUEST FOR DRUG PRIOR AUTHORIZATION



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

Requests for prior authorization must include patient name, Medicaid ID#, and drug name. Appropriate clinical information to support the request on the basis of medical necessity must be submitted. **SUBMISSION OF DOCUMENTATION DOES NOT GUARANTEE COVERAGE BY THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AND FINAL COVERAGE DECISIONS MAY BE AFFECTED BY SPECIFIC MEDICAID LIMITATIONS.**

The completed form may be **FAXED TO 800-932-6651**. Requests may be phoned to 800-932-6648.

Requests may be mailed to: First Health Services Corporation / 4300 Cox Road / Glen Allen, VA 23060 / ATTN: MAP

PATIENT INFORMATION

Patient's Name:

Patient's Diagnosis:

Patient's Medicaid ID#:

Patient's Date of Birth:

DRUG INFORMATION

Drug Name & Strength:

Quantity Per Day:

Has patient had previous pharmaceutical therapy for the above diagnosis? ☐ Yes ☐ No

List pharmaceutical agents attempted and outcome:

1.

2.

3.

Medical necessity: Provide clinical evidence that the preferred agent(s) will not provide adequate benefit:

PHYSICIAN INFORMATION

Physician's Name (print):

Date:

Physician's Signature:

Phone #:

Physician's DEA#:

Fax #:

**PLEASE INCLUDE ALL REQUESTED INFORMATION
INCOMPLETE FORMS WILL DELAY THE PRIOR AUTHORIZATION PROCESS**

FAX TO 800-932-6651

PRIOR AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE AND THUS DRUG COVERAGE

A copy of the PA form is available at <http://www.dmas.state.va.us/pharm-home.htm> or at <http://virginia.fhsc.com>.